scaphoid is thus brought to a normal position with the astragalus and the calcaneus can be replaced also. The foot is then fixed with splint in normal position. In the third class the Achilles tendon is divided subcutaneously, but to this is added an open incision, extending from a line joining the inferior border of the int. malleolus to Chopart's articulation, perpendicularly 3 or 4 cm. toward the plantar surface of the foot. The tibialis posticus, the lateral ligament, flexor longus digitorum, the abductor hallucis, flexor hall. long. are according to necessity divided. Plantar fascia and flex. brev. are divided if offering any resistance, the foot being strongly redressed at intervals during the operation. After operation plaster bandage is applied until the wounds have healed. Then the elastic apparatus of Phelps can be used to keep the foot in good position. In paralytic club-foot belonging to the third class, carry the above elastic apparatus permanently. In the Hamburg general hospital the wound after the operation is covered lightly with protective, then sublimate gauze dressing, and this is covered with turf moss cushion, and finally plaster bandage. After four weeks this is removed, and a removable plaster and water-glass bandage put on for six to twelve weeks. This last splint reaches to the knee, and the patient is able to walk in it. The patient is then fitted with the removable plaster boot of Dr. Hausmann. (*Archiv. f. klin. Chir.*, Bd. 32, s. 989.) *Deutsche Zeitsch. f Chir.* Bd. xxv. heft. 3.

HENRY KOPLIK (New York)

III. Osteotomy, a Radical Cure for Hammer-Toe. Dr. EUGÈNE COHEN (Paris).—In this affection the toe is continually in a state of extension on the metacarpal bone, the interphalangeal joint is extremely flexed, and the last or small phalanx is either bent under the toe or points forwards. The skin becomes so irritated that a bunion is soon developed, and inflammation is often so bad that the toe has to be amputated. M. Terrier was the first to practice excision of the joint. A large circular flap, including the bursa, is cut over the joint which is then opened. The extensor tendon with its sheath is cut through, as are also the two lateral ligaments. The two articular sur-

faces are then cut away with the bone nippers. Horse hair sutures have to be put into the skin only, and a small drainage-tube is left in the wound. A small splint is bandaged on, and all due antiseptic precautions having been taken, cure is completed in a fortnight, and the patient able to walk about.—*Le Progrès Medical*, Aug. 20, 1887.

LEONARD MARK (London.)

IV. On Arthrectomy of the Knee-Joint in Children. By DR. MANDRY (Tuebingen). The author calls attention to the various phases in the history of resection of the joints, their enthusiastic reception at the commencement of the antiseptic era in surgery, and their restriction in the tuberculous disease of joints, where it became apparent that complete eradication of the tissue was not always affected by these means. Moreover, in the knee-joint in children, typical resections were followed by serious defects in the growth and position of the joint, so that with this joint a typical resection is now almost universally acknowledged an unjustifiable operation. He advocates extirpation of the capsule and scraping out of any tuberculous foci, a practice which in seven cases at Tuebingen led to excellent results; in four of these cases healing per primam resulted; in two others with circumscribed suppuration, and in one case incision and scraping of the fistulous ducts had to be repeatedly resorted to. In one of the cases that had apparently healed per primam a tuberculous focus had unfortunately been overlooked, and resection became necessary later on. The operation is performed in the following way: Incision over and through the patella or the tendon of the quadriceps; extirpation of the entire capsule with forceps and scissors; thorough scraping in bone and soft parts of any tuberculous matter; no healthy cartilage or bone substance is removed; irrigation with sublimate-solution; suture of the quadriceps or patella with dropped catgut or sea-grass stitches; suture of the skin; Watson's splint; and finally Plaster-of-Paris bandage to counteract the tendency to flexion. If the latter should develop, forcible extension is practised, and a new Plaster of-Paris dressing applied. The final results after $2^1/_2$—$3^1/_2$ years showed in one case almost normal mobility of the joint. Five times ankylosis (in